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Introduction

In the UK, adoption provides stability and permanence for a minority of children unable to live with birth family. In the year ending 31 March 2015, 5,715 children were adopted from local authority care in England and Wales. The total care population at that time was 75,155 (Department for Education, 2015; Welsh Government, 2015).

Children adopted from the care system carry with them a number of risks known to jeopardise optimal development. Most will have experienced maltreatment within their birth family (Selwyn *et al.*, 2015). The evidence for the harmful effects of abuse and neglect in childhood is compelling. It is associated with impaired functioning in many developmental domains, including cognition, learning ability, social interaction, physical and mental wellbeing and behaviour (Meadows *et al.*, 2011; Norman *et al.*, 2012). Associations have also been identified between the trauma triggered by maltreatment and significant structural and functional impacts on brain development (McCrory *et al.*, 2010; Jaffee & Christian, 2014). Other factors known to compromise development include genetic vulnerabilities and pre-natal experiences, such as maternal stress and exposure to alcohol and drugs (British Medical Association, 2007; Talge *et al.*, 2007; Behnke and Smith, 2013). These too are developmental risks often carried by children adopted out of the care system (Rushton, 2003; Selwyn *et al.*, 2006; Selwyn *et al.*, 2015).

There is good evidence that adoption can provide a stable and secure base, through which children can recover developmentally (van den Dries *et al.*, 2009) and thrive in the long-term (Palacios & Brodzinsky, 2010). Meta-analysis has shown that adopted children fare better than their peers who remain in care, with marked improvements in growth, attachment

security and cognitive capabilities (van Ijzendoorn & Juffer, 2006). However the impact of early adversity does not simply disappear once a child is provided with the stability of adoption. Adoption as an intervention without (as well as sometimes with) the provision of additional support, is not always enough to help a child overcome a difficult start in life. Many adopted young people present with complex and enduring needs (Selwyn *et al.*, 2015).

In recent years, adoption reform has been high on the political agenda in England and Wales, including a commitment to better support adoptive families. In 2014, the enhanced pupil premium in England was extended to include adopted children. Pupil premium monies are used by schools to provide additional emotional, social and educational support to disadvantaged children. In 2015, the Adoption Support Fund was also introduced in England to help families in difficulty access specialist adoption support when needed. Adoption support services also form part of the remit for the new national adoption service provision and vision in Wales.

Several recent UK studies have examined the experiences and provision of the support for adoptive families (see for example, Pennington, 2012; Ottaway *et al.*, 2014). These studies have focused primarily on the support provided by local authorities and that of specialist or therapeutic services, such as child and adolescent mental health services. Much less is known about the role of universal health care services in supporting adoptive families and little attention has been afforded to examining the ways in which health visitors might support families with young children placed for adoption. Bonin and colleagues (2014) examined the services used by families during the first six months of an adoptive placement. In their small sample, health visitors or community nurses had been involved with three quarters of the adoptive families, with 77% of these families rating the intervention as useful. However, the

study did not report on the specific needs of the families, nor nature of the support shown to them.

This paper draws on a national adoption study to examine the characteristics and experiences of children recently placed for adoption. With a focus on relevance to health visiting, it considers the early concerns, support needs and experiences of new adoptive families and examines the role that health visitors play in supporting the families, as part of routine health intervention for children.

Methods

The overarching aims of the mixed-methods study¹ were to examine the characteristics and experiences of a cohort of children placed for adoption in Wales UK, to consider the early support needs of adoptive families and to better understand what helps families to flourish. Data collection comprised three strands: 1] Review of social work records - specifically the Child Assessment Report for Adoption (CARA); 2] Questionnaires to newly formed adoptive families; and 3] Interviews with adoptive parents.

[1] Three hundred and seventy four CARA records were reviewed, comprising the records of all children placed for adoption in Wales between 01 July 2014 and 31 July 2015. The records contain information that social workers must include when reporting on children put forward for adoption. They hold a record of children's experiences and needs within the domains of health, education, emotional/behavioural development, self-care skills, identity, family and social presentation. They also set out the characteristics and

¹**Wales Adoption Cohort Study**, funded by Health and Care Research Wales, a Welsh Government body that develops, in consultation with partners, strategy and policy for research in the NHS and social care in Wales (Grant reference: SC-12-04). Ethical permission for the study was granted by the ethics committee at Cardiff University, School of Social Sciences. In addition, permission from the Welsh Government was obtained to carry out the study using local authority data.

experiences of birth parents, the reasons children were placed for adoption and the actions taken by the local authority.

[2] Ninety six adoptive families completed a questionnaire around four months after the start of a new adoptive placement. Families eligible for inclusion in this part of the study were those with whom a Welsh child had been placed for adoption between July 1st 2014 and July 31st 2015. The characteristics of the 96 children whose families participated in the study were compared to all Welsh children placed for adoption during the study period (n=374). Our sample is representative of children placed during the study window for gender and past experiences of abuse/neglect. Our sample of children were slightly older because we asked adoptive parents of sibling groups (30% of the sample) to comment on the eldest child placed for adoption.

As well as eliciting information on the background characteristics and support needs of the adoptive families, parents also completed standardised measures, including the Strengths and Difficulties Questionnaire (SDQ), (Goodman, 1997). The SDQ is a well validated, brief behavioural screening tool comprising 25 items in 5 scales: Emotional symptoms, conduct (behaviour) problems, hyperactivity, peer problems, and prosocial behaviour.

[3] Forty adoptive parents were interviewed. The sample was drawn from families who had completed the questionnaire. Interviews typically took place about nine months after the start of the adoptive placement. The interviews were conducted in the adoptive home and lasted, on average, two hours. They were designed to help understand more about the early experiences and support needs of adoptive families.

Analysis

Quantitative data were entered into SPSS to facilitate the generation of descriptive statistics, using measures of central tendency and variability. Drawing largely on the guidance provided by Braun and Clarke (2006), the fully transcribed interview material and the open ended responses in the questionnaire were analysed thematically in 5 key stages: 1) All material was read and re-read to promote familiarisation with the entire data set. 2) Codes were applied to sections of the data to help identify the important features relevant to understanding the support needs of the adoptive families. Whilst some material was coded from concepts that had been identified at the outset of the fieldwork, others were generated from within the dataset. 3) Emerging and recurring patterns (themes) in the coded data were drawn out. 4) The material within, and the relationships between the themes were reviewed and refined to ensure that the datasets were accurately represented. 5) The parameter of each theme was defined and the content analysed to produce a coherent account of the narratives. Nvivo 10 was used to explore the qualitative data.

Results

Material derived from all three data sources is drawn on to present the emergent findings of relevance to health visiting practice.

Characteristics and histories of children placed for adoption (n=374)

Just over half (54%) of all children placed for adoption in Wales between 01 July 14 - 31 July 15 were boys; the vast majority were white British (94%), with English identified as the child's first language (98%). The average age of the children on entry to care was 1 year 2 months (range 0 months - 6 ½ years). Two fifths (41%) became looked after at, or shortly after birth

and thus had never been in the sole care of a birth parent. Just 4% (n=10) were over the age of five on entry into care. Children spent on average, 528 days in care before being placed for adoption (range 129 - 2661 days). Nearly two thirds of the children (n= 273, 65%) had one foster placement whilst in care. A fifth (n= 76, 20%) had two foster placements, whilst 55 children (15%) had three or more foster care placements before moving into their adoptive home. The average age of the children at the time of their adoptive placement was two years, seven months. The vast majority of the children (n=334, 87%) were placed for adoption under the age of five. A third moved into their adoptive home as part of a sibling group.

Developmental concerns were recorded for nearly a fifth (18%) of all children. Concerns about attachment styles and behaviour were recorded for 17% of the children. Seven percent were reported as having a serious and enduring health problem or disability. Of the 220 children who had lived with a birth parent before entering care, 210 (94%) were known to have been abused or neglected, whilst 58% (n=120) had been exposed to domestic violence. Nearly all children who entered care at birth, had been at risk of maltreatment. In more than half of these instances (53%), serious domestic violence was known to have occurred whilst the birth mother was pregnant with the child. Of those children whose prenatal history was reported (n=322), nearly a third (32%) were known or believed to have been exposed to drug or alcohol abuse *in utero*. Just 10 infants (4%) were voluntarily relinquished by birth parents.

Characteristics of the adoptive families in the questionnaire (n=96) and interview (n=40) sample

The following tables set out the key characteristics of the families in the questionnaire and interview samples.

Table 1: Key characteristics of the families in the questionnaire and interview samples

	Questionnaire Sample (n=96)		Interview Sample (n=40)	
	N	%	N	%
Adopter status				
Heterosexual couple	79	83	31	78
Same sex couple	5	5	3	7
Single adopter	12	12	6	15
Child Gender				
Male	49	51	23	57
Female	47	49	17	43
Age of child when placed for adoption				
Under 12 months	24	25	9	22.5
12 - 35 months	30	31	14	35
36 - 59 months	20	21	9	22.5
60 months +	22	23	8	20
Child placed for adoption with sibling/s				
No	67	70	30	75
Yes	29	30	10	25

Notably, just over three quarters of all children (n=74, 77%) in the questionnaire sample had been placed for adoption under the age of 60 months (5 years) and therefore of an age eligible for services routinely provided by Health Visitors. In four fifths (n=32) of the families interviewed, the child was under the age of 5 when placed for adoption; all had been in contact with their health visitor. The findings presented in the remainder of this paper relate specifically to these children. Just two families in the study, were eligible for an enhanced health visiting service, through 'flying start' (a scheme forming part of the early years programme in Wales, for families with children living in disadvantaged areas). However the accounts of their contact with health visitors were not discernibly different from families in rest of the sample.

The support needs and experiences of the newly formed adoptive families

Drawing on the interview material and complemented by the questionnaire data, it was possible to **theme** the early support needs of the adoptive families into one of six key areas; 1] children's physical health and development; 2] children's emotional and behavioural wellbeing; 3] strengthening family relationships; 4] promoting children's identity; 5] contact with birth family and significant others and 6] financial and legal matters.

The findings that follow examine the experiences of the adoptive families specifically in relation to the children's physical health and development and their emotional and behavioural wellbeing - two matters that fall directly within the province of health visiting. We also report on parents' views and experiences of their contact with health visitors in the first few months of adoptive family life.

Physical health and development

A pronounced anxiety for parents in the early days of adoptive family related to concerns about their child's physical health and development. When parents were asked in the questionnaire to describe any concerns they had in caring for their child, 28% (n=21) identified developmental matters. Several parents simply recorded 'developmental delay', but nearly a fifth of all parents (19%, n=14) specifically mentioned concerns about their child's speech and language skills and/or poor gross motor skills. For example:

She is not speaking yet, only saying a few words and is now two years old.

Speech and language delay. He is beginning to get frustrated when people don't understand him.

Our little girl is 16 months old and not walking. She only started sitting without support and with confidence at about 14½ months. We were aware before placement ... that she had some physical developmental delay.

At interview, parents sometimes offered a context to their concerns, describing how they believed their child's early neglectful care experiences had hindered optimal development. One mother explained what she knew about her son's experiences before entering care, aged 14 months:

He had been in a high chair for all that time basically, so his legs were just unusable, he'd never walked, he'd never been bounced.

For some, concerns about their child's development had been compounded by not having been prepared for possible arrests or setbacks, as one mother observed:

[We have] developmental concerns. She was on verge of walking when placed, but this took another 3 months to achieve. I feel that the disruption of the adoption set her back. No-one prepared us for this.

At interview, parents were asked about support provided by health visitors. Parents reported having received useful advice about managing common physical ailments, such as minor infections and localised eczema. Health visitors had also carried out many routine developmental checks on the children. In the course of their contact with the families, as many as 10 of the 32 children had been referred on by the health visitor to specialist services (such as, speech and language, physiotherapy, podiatry, audiology, ear, nose and throat and ophthalmology). However, there were other instances when concerns raised by adopters about children's health and development had not triggered an onward referral. Not uncommonly, parents described how the health visitor had been able to provide them with the support they needed simply by way of reassurance. Parents explained that the health

visitor had provided a context to their concerns and whilst acknowledging that children had not yet met certain developmental milestones, had encouraged parents to consider the huge amount of progress children had made since arriving in their adoptive home. This reassurance was considered by parents an important component of the support provided by health visitors, as illustrated in the following account.

I use the health visitor to just, to go in and say 'Is this normal?' or, you know 'Is she doing the right things?' or 'Is she growing ok?' So it's just more reassurance for me, to go in and have a chat with the health visitor.

Eating, sleeping and toileting: In the questionnaire, one in eight parents had uncertainties or concerns about their child's eating habits, although the nature of these were varied. For example, parents were worried that children were not eating enough, were eating too much, or were refusing to eat a balanced diet. Concerns about food intolerances and appropriate finger foods were also identified. Several parents were worried about the mechanics of eating, including children's inability to feed themselves, or properly chew their food:

She hadn't been weaned, she had only had milk up until entering care [aged 13 months]. The eating issues she had were quite severe really and even now when I give her things like blueberries, she just doesn't know what to do with them. We gave her some apple and we thought she had eaten it, but two hours later [husband] found it when she was in the bath. She had just kept it in her cheek. She just did not know what to do with it.

Parents also worried about their child's sleep routine - either their inability to get to sleep or their disturbed sleep pattern. A couple of children had been troubled by night terrors. For some, concerns were again exacerbated because of what parents saw as set-backs in the children's progress since moving into their adoptive placement. Health visitors had been instrumental in helping families to address sleep problems.

She would wake up early hours of the night and there seemed to be no reason for it. She would want to just be held for a couple of hours then she would go back to sleep. At the time it was a bit worrying thinking she wasn't getting enough sleep. We went down the route of the health visitor for most of our questions ... We are so lucky, we have a great health visitor, so we had books, we did some research and ended up doing a bit of sleep training, which was good.

Parents also expressed concerns about toileting, including problems with constipation and with smearing. Most often, however, the concerns related to parents' anxieties about children's lack of progress with toilet training. Parents described children who seemed disinterested in toilet training, who refused to sit on the potty and who had 'accidents'. Concerns were generally well alleviated by the health visitor, who encouraged parents to avoid becoming preoccupied with toileting and offered reassurance that children would be 'nappy-free' in due course. Occasionally, parents wondered if they had over-analysed the situation, in that children's 'refusal' to toilet train was simply because they were not yet ready, rather than because of their early trauma.

In the main, the health visiting support provided for concerns about children's eating, sleeping and toileting habits was valued by parents. However, there were instances when parents had thought that the routine advice given had not taken into account the wider needs of their child. One mother, for example, explained how her health visitor had been pressing her to get her 18 month old son 'off the bottle' as soon as possible. The mother felt that the opportunity that bottle feeding provided, in terms of helping to promote a close emotional bond, was more important than a progression to cup feeding at this point in her son's life. She valued the close physical contact, intimacy and nurturing that bottle feeding afforded.

Emotional and behavioural wellbeing

Nearly a third (n=16, 31%) of adopters parenting children aged between 12-59 months at placement identified concerns about their child's behaviour. Parents were particularly worried about aggressive and controlling behaviours:

He has started to display some defiant and challenging behaviour and wants to control everything.

Violence towards me and abusive - hitting, punching, biting, scratching, kicking, calling me a stupid bitch and telling me to shut up.

A few parents simply wrote 'temper tantrums' when reporting their concerns. We do not know whether these families were also facing some of the very challenging behaviours, described in more detail by other parents. Parent sometimes expressed uncertainty about the trigger for the difficulties; they wondered if this was simply the 'terrible twos', or whether the behaviour was a consequence of their child's poor start in life. The difficulty for parents in knowing what concerns were linked to the effects of children's early adversity, and what were to be expected as part of 'normal development', is a matter to which we return. Whilst not reported on in detail here, it is worth noting that the results from the SDQ, completed by adopters parenting children aged between 24-59 months, showed that compared to population norms, the children were rated higher than average in their poor prosocial behaviour, poor peer relations and hyperactivity.

When parents were asked at interview about any help or advice they had sought in relation to concerns about their child's challenging behaviour, most reported very little discussion with health visitors. Just two mothers had asked the health visitor specifically about how best to respond to their child's aggressive outbursts towards other children. Both reported receiving constructive advice. Parents who had sought help, had tended instead to approach

their child's social worker, albeit with varied amounts of satisfaction with the support and advice provided.

The perceived quality of parents' relationship with their health visitor

In the interview sample, all 32 adopters parenting a child under the age of 5 at placement had been seen by a health visitor. In several instances, this contact had been brief, usually with an open invitation to attend various clinics run by the service. However, for some families, the contact had been much more involved. Several parents described the health visitor as an excellent source of support in the early days of adoptive family life. For example:

Chloe is still what they call a looked after child. The health visitor has been really on to it. We get on really well with her, we've got a really good relationship. So whilst other people have been lacking in giving us support, I have to say that the health visitor has been amazing.

You know who was really good actually, was the health visitor. She was a brilliant source of advice because she knew I was a new parent, she gave me lots and lots of advice about lots of things ... she said 'if you need me, call me'.

The ease with which parents felt able to confide in their health visitor was notable. Often, a different set of dynamics existed between parents and other service providers and one which was sometimes characterised by a perceived power imbalance. The contact parents had with health visitors did not seem to attract this feeling of inequity, nor the same level of guardedness that some parents described in relationships with their child's social worker. Furthermore, the adoptive status of the family was felt to be of less significance when liaising with health visitors. One mother explained:

The health visitor has been very supportive and it has felt like I could be a parent with her, rather than an adoptive parent ... it is a new relationship that only came about because I am a parent, that has felt quite nice really.

According to parents, contact with the health visitor usually had no discernible adverse effect on the children. In contrast, parents reported that the contact children had with their social worker was often stressful. Accounts were given of children becoming extremely anxious, bedwetting, having rages and night terrors following visits by social workers to the adoptive home. Parents usually thought that children associated their social worker with being removed from 'home'. Two children did become agitated in the presences of anyone they perceived as an authority figure, including the health visitor.

The continuity of the relationship with the health visitor was also valued, especially once the adoption order was made and when contact with other professionals dropped away.

The health visitor came for his two year check recently, then she said, 'I don't need to see you for another year.' My face must have dropped or something. It is quite strange now because literally once the final hearing is done that's it, everyone walks out ... So the health visitor said 'I can come back in three months.' it's nice to just check with somebody, who can say 'well yeah, actually you are doing a good job, he's fine, great, we're not worried, everything is going the way it should be'.

Discussion

The findings from this study provide contemporary evidence about the adversity and disadvantage faced by children placed for adoption in the UK today. The vast majority of children in our sample who had lived with birth family before entering care, had been maltreated. Most others had been removed from their birth family due to the risk of significant harm. Infants who entered care at birth were not immune to early disadvantage - with exposure to drug and/or alcohol abuse and to domestic violence *in utero*. It should also be remembered that in their short lives, nearly all children had experienced one or more changes in primary carer. Some had multiple carers and had lived in a number of different

home settings before moving in with their adoptive family. Given these early experiences, it is perhaps not surprising that parents reported challenges in early adoptive family life, including arrests in children's development and behavioural challenges. This is clearly an important context for health visitors to consider when supporting families with children recently placed for adoption.

The study revealed a range of concerns and support needs of the newly formed adoptive families, many of which, arguably, affect all types of family containing young children, adopted or otherwise. For example, eating, sleeping and toileting habits, as well concerns about overall development. Findings suggests that health visitors are well placed to support newly formed adoptive families. Parents were reassured by health visitors, who were in a position to offer routine and 'ordinary' monitoring and assessment of adopted children, not because they are adopted, rather because they are children. However, the findings also revealed a high number of onward referrals by health visitors. It is difficult to concede that health and developmental concerns only surfaced for so many of the children after they had moved into their adoptive home. More likely, it seems that children's difficulties had not always been picked up on, or responded to whilst living in foster care or with birth family.

A number of parents faced difficulties in managing and understanding some of the challenging behaviours shown by the children. Notably however, this was a matter not widely discussed with the health visitor. The higher than average levels of poor prosocial behaviour, poor peer relations and hyperactivity evidenced in the SDQ, suggests that parents were aware of fairly serious levels of dysfunction and distress in some children. Parents were sometimes confused about the origins of their children's challenging behaviour - uncertain whether children were having 'toddler tantrums' associated with normal development, or were showing behaviours

linked to their early adversity. Emotional and behavioural difficulties have been associated with the chronic stress that children experience as a result of maltreatment. This can lead to an alteration in the stress response, evidenced by abnormal cortisol patterns, hyper-vigilance, changes to reward processing and errors in correctly identifying emotions (McCrory et al. 2010; Jaffe & Christian, 2014). Whilst it is important to not pathologise adopted children, especially at such a young age, it is salient to recognise that a minority are likely to have enduring emotional, behavioural and social difficulties arising from their early traumatic life experiences. There is potential here for the health visitor / parent relationship to provide an important source of support for these families, particularly in relation to onward referral for early, targeted support. This relies though, not only on health visitors being aware of the possibility of such difficulties and able to raise questions as a matter of routine, but also being able to engage in such a way, that parents feel safe enough to expose their concerns.

Whilst adopted families may benefit from 'standard' advice about managing children's difficult behaviours, it is also important for health visitor to recognise that some of the more traditional 'reward / punishment' parenting strategies are not appropriate interventions to recommend for children with a history of abuse and neglect (Elliot, 2013).

Overall, parents seemed to enjoy relaxed contact with health visitors, who they regarded a valuable source of reassurance. Parents enjoyed the 'ordinariness' of their relationship with the health visitor, which had come about because they were parents and not specifically adoptive parents.

Conclusion

Health visitors are in a privileged position to support newly formed adoptive families. As part of a universal service, health visiting does not carry the same stigma that other service

provision, such as social work, might. Our study reveals evidence of some good practice by health visitors in working with newly formed adoptive families and highlights the role that the health visiting service could further play, in supporting adopted children and their forever families.

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